PATIENT HISTORY FORM

Name____ Date ____________________

Address ______________________________ City_____________ State________ Zip __________

Date of Birth ________/ ________/ ________ Home Number ______________ Cell____________________

What is the main reason for today's visit? ____

How did you hear about us? ____

Email Address ____

Insurance Information Insurance Name __________________________ S.S# __________________

Insured's Name ____________________________________ Date of Birth _______/ _________/_________

Eye History

Do you or have had…

Eye History	Yes	No	Family History
Eye Surgery	☐	☐	
Eye Trauma	☐	☐	
Cataracts	☐	☐	☐
Glaucoma	☐	☐	☐
Macular Degeneration	☐	☐	☐
Retina Detachment	☐	☐	☐
Strabismus / Lazy Eye	☐	☐	☐
Color Vision Defect	☐	☐	☐

General History

Do you or have had…

General History	Yes	No	Family History
High Blood Pressure	☐	☐	☐
Diabetes	☐	☐	☐
High Cholesterol	☐	☐	☐
Arthritis	☐	☐	☐
Heart Problems	☐	☐	
Thyroid Disorder	☐	☐	
Stroke	☐	☐	
Cancer	☐	☐	

	Yes	No	
Are you taking medications?	☐	☐	If yes, please list ______________________
Do you have allergies?	☐	☐	If yes, to what?______________________
Are you pregnant?	☐	☐	
Any other physical problems?	☐	☐	If yes, please explain______________________

Lifestyle Questions

Occupation:______________________________ Hobbies / Activities:______________________________

	Yes	No		Yes	No
1. Do you work or use a computer often?	☐	☐	3. Are you around water frequently?	☐	☐
2. Do you do much night driving?	☐	☐	4. Do you have problems with glare?	☐	☐

I have read and understood the HIPAA privacy policy:______________________________Date:______________

Signature

MEDICAL HISTORY REVIEW: I have read this medical history and have added any changes since my last review.

________________ ________________ ________________ ________________

PATIENT HISTORY FORM

Initial:________ Date:_______________	Initial:________ Date:_______________	Initial:________ Date:_______________	Initial:________ Date:_______________